STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445260	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH CARE CENTER	100 ELMHURST DR OAK RIDGE, TN 37830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide hazardous areas with self-closing doors. The findings include: Observation on September 24, 2013 at 12:03 p.m. and 1:55 p.m. revealed that the West Side Shower Room and the East Side Shower Room each have storage closets over 50 square feet containing combustible materials. These storage closet doors are not equipped with a door closure. This finding was verified by the maintenance assistant and acknowledged by the administrator during the exit conference on September 24, 2013.	K 029	This Plan of correction is prepared and executed because it is required by the provisions of State and Federal law, and not because Briarcliff Healthcare Center agrees with the allegation(s) and citation(s) listed on this statement of deficiencies. Briarcliff Healthcare Center maintains that the alleged deficiencies do not individually or collectively constitute substandard care or jeopardize the health and safety of the residents; nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also serve as the facility's written credible allegation of compliance. **K029** The West Side Shower room door and the East Side Shower room door were both equipped with a door closure. All Storage doors will be inspected by the Maintenance director/designee by 10/11/13. Maintenance staff will be in-serviced to inspect all storage closet doors monthly. This inspection will be reviewed by the administrator monthly for 3 months and then quarterly.	**10/25/13**
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Smith	Administrator	10/11/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 050	Continued From page 1 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure staff members are familiar with proper fire drill procedures. The findings include: Observation on September 24, 2013 at 2:15 revealed that the staff member discovering and initiating the fire drill did not close the resident room door where the fire scenario was given at and resident room doors to 509, 510, 511, 512, and 513 were not closed during the fire drill. This finding was verified by the maintenance assistant and acknowledged by the administrator during the exit conference on September 24, 2013.	K 050	**K050** The staff member involved received an individual in-service on 10/9/13. All Staff will be in-serviced on fire drill procedures related to securing the area by closing the doors by 10/25/13. The Maintenance director/designee will submit the monthly fire drill reports to the administrator for review.	10/25/13
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by:	K 054	**K054** The smoke detectors indicated were moved on 10/2/13. Maintenance director/designee will inspect all smoke detectors to ensure that they are at least 3 feet from air flow and any issues will be addressed. Maintenance staff was in-serviced to inspect all smoke detectors distance from air flow.	10/25/13

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K 054	Continued From page 2 Based on observation, the facility failed to have smoke detectors at least 3 feet away from air flow. The findings include: Observation on September 24, 2013 between 10:50 a.m. and 11:20 a.m. revealed that the following areas have smoke detectors within 3 feet of air flow: 1. Corridor by room 201. 2. West side day room. 3. Corridor by the admission coordinator's office. These findings were verified by the maintenance assistant and acknowledged by the administrator during the exit conference on September 24, 2013.	K 054	**K062** Sprinkler heads under the front canopy were replaced on 10/9/13. All sprinkler heads will be inspected for corrosion or tarnish by 10/18/13 and any issues will be corrected. Maintenance staff will be in-serviced on conducting monthly inspections of sprinklers. The monthly inspections will be reviewed by the administrator for 3 months and then quarterly.	10/25/13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the automatic sprinkler system components. The findings include: Observation on September 24, 2013 at 11:22 a.m. revealed all sprinkler heads under the front	K 062		

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K 062	Continued From page 3 drive through canopy are corroded or tarnished. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on September 24, 2013.	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide metal containers with self-closing	K 066	**K066** New metal containers with self-closing covers were ordered on 10/9/13 for both smoking areas. All other smoking areas will be inspected by the Maintenance director/designee by 10/11/13. Maintenance staff will be in-serviced by 10/11/13 to inspect smoking areas to ensure the metal containers with self-closing covers are available. The Maintenance director/designee will submit the monthly inspections to the administrator for review for 3 months, then quarterly.	10/25/13

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K 066	Continued From page 4 devices into which ashtrays can be emptied into. The findings include: Observation and interview with the maintenance director on September 24, 2013 at 11:25 a.m. revealed that 2 of 2 smoking areas are not provided with a metal container with self-closing lid into which ashtrays can be emptied into. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on September 24, 2013.	K 066		